THE COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS
600 WASHINGTON STREET, 7TH FLOOR
BOSTON, MA 02111

Mitt Romney
Governor

Kerry Healey
Lieutenant Governor

Jane C. Edmonds
Director of Workforce Development

Angelo R. Buonopane
Director of Labor

John C. Chapman
Acting Commissioner

OFFICE OF INSURANCE

INSURANCE REGISTER (617) 727-4900, extensions 404 or 405.

INSURANCE INQUIRY FORM

Only this most recently revised version of the insurance inquiry form is to be used to request insurance information. Photocopies of this form are acceptable - any other version of this form will be rejected.

Please type or print responses to the following. Please be sure to write your name and address on the bottom of this form, so the results of the research may be reported to you. If you fax this form to us, we cannot fax back the findings. All findings will be returned by mail.

Remember that the company name at which the injury took place may not be the actual name of the policyholder. The policy name is usually the legal name of the entity which should be found on the employee's paycheck deduction stub, or W-2 form. If there are no sources available that can provide the legal name, list any additional names (along with the company name) that might be the policy name.

COMPANY NAME (s) _____

ADDRESS _____

_____

WHAT IS ANOTHER NAME UNDER WHICH THE COMPANY COULD BE OPERATED?

_____

DATE OR PERIOD OF INJURY _____

HOW LONG HAS THE COMPANY BEEN IN BUSINESS? _____

WORKERS' COMPENSATION INSURANCE INFORMATION SHOULD BE REQUESTED FROM THE EMPLOYEE'S COMPANY FIRST. CALL AND ASK TO SPEAK WITH THE APPROPRIATE PERSON AT THE COMPANY WHO WOULD HAVE THE KNOWLEDGE OF THIS INFORMATION.

IF INSURANCE INFORMATION CANNOT BE FOUND FOR THE EMPLOYER NAME SUBMITTED, SUCH A FINDING DOES NOT NECESSARILY MEAN THAT THE ENTITY WAS NOT OR IS NOT INSURED.

YOUR NAME AND ADDRESS (TO MAIL BACK THIS FORM TO YOU):

_____

_____

_____

Tel. 617-727-4900 - www.mass.gov/dia